OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9043

TRICARE
MANAGEMENT ACTIVITY
PDR

CHANGE 70
OCHAMPUS 6010.50-M
August 7, 1998

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR AUTOMATED DATA PROCESSING AND REPORTING MANUAL

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING CHANGE(S) TO OCHAMPUS MANUAL 6010.50-M, REISSUED JULY 1992:

PAGE CHANGE(S): **CHAPTERS 6 AND 9.**

REMOVE AND INSERT PAGE(S): **(See page 2 of this transmittal)**

SUMMARY OF CHANGE(S): THIS CHANGE IMPLEMENTS PROVISIONS OF THE FEBRUARY 24, 1998, FINAL RULE WHICH ELIMINATES THE INAS REQUIREMENT FOR OUTPATIENT MATERNITY CARE. THIS CHANGE IS ISSUED IN CONJUNCTION WITH POLICY MANUAL CHANGE NO. 29, AND OPERATIONS MANUAL CHANGE NO. 119.

EFFECTIVE DATE AND IMPLEMENTATION: THE EFFECTIVE DATE IS AS INDICATED ON THE ATTACHED PAGES. IMPLEMENTATION IS UPON DIRECTION OF THE CONTRACTING OFFICER.

Sheila H. Sparkman
Director, Program Development and Evaluation

ATTACHMENT(S): 15 PAGE(S)
DISTRIBUTION: 6010.50-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH THE BASIC DOCUMENT

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 6	
6.II-7 & 6.II-8	6.II-7 & 6.II-8
6.IV-9 THROUGH 6.IV-12	6.IV-9 THROUGH 6.IV-12
CHAPTER 9	
TABLE OF CONTENTS i & ii	TABLE OF CONTENTS i & ii
9.II-3 THROUGH 9.II-8	9.II-3 THROUGH 9.II-9

Element Name: NAS Number (2-110)

Validity Edits

2-110-01 IF NAS NUMBER IS CODED

POSITION 2 - 4 (DMIS FACILITY #). MUST BE VALID (USER SUPPLIED USE MTF NUMBERS).

POSITION 1 MUST BE ZERO.

POSITION 5 - 8 (JULIAN DATE; FORMAT YDDD). Y MUST BE 0 - 9. DDD MUST BE 001 - 366.

POSITION 9 - 11 (SEQUENCE #). MUST BE NUMERIC AND NOT ZERO.

OR

POSITION 1-2 MUST BE '46' **OR** '47' AND POSITION 3-11 MUST BE ZEROS. AND EITHER BEGIN DATE OF CARE < 11/1/92 **OR** FILING STATE/COUNTRY CODE ≠ NUMERIC **OR** 'PR'.

IF NAS NUMBER IS NOT CODED. MUST BE BLANK-FILLED.

Relational Edits

Related to Element	Edited Element Relationship	Also Relates to Element(s)
NAS EXCEPTION REASON	SEE BELOW	TYPE OF SERVICE. PATIENT ZIP CODE. SPONSOR BRANCH OF SERVICE. DENIAL REASON CODE. CARE BEGIN DATE. PROGRAM INDICATOR
TYPE OF SERVICE	SEE BELOW	
PATIENT ZIP CODE	SEE BELOW	CARE BEGIN DATE

Edited Element Relationship

NO ERROR IF SPECIAL PROCESSING CODE = MS MEDICARE SUBVENTION/TRICARE-SENIOR PRIME *(NETWORK)*

MN MEDICARE SUBVENTION/TRICARE-SENIOR PRIME (NON-NETWORK)

NO NAS NUMBER IS REQUIRED -- BYPASS ALL NAS NUMBER EDITING.

2-110-02R IF PATIENT ZIP CODE IS NOT IN A CATCHMENT AREA[1]
NAS NUMBER MUST = BLANK
UNLESS SPECIAL PROCESSING CODE = 'ST'.

2-110-03R IF NAS EXCEPTION REASON IS NOT BLANK
NAS NUMBER MUST = BLANK.

2-110-04R IF BEGINNING DATE OF CARE ≥ 9/23/96
AND

ENROLLMENT STATUS E MANAGED CARE SUPPORT TRICARE TIDEWATER PRIME

O NEW ORLEANS PRIME

[1] ***FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.***

Element Name: NAS Number (2-110) (Continued)

		H	MANAGED CARE SUPPORT HOMESTEAD ENROLLED PATIENT
		K	MANAGED CARE SUPPORT CALIFORNIA/HAWAII. TRICARE PRIME ENROLLED PATIENT
		U	MANAGED CARE SUPPORT PRIME. CIVILIAN PCM
		Z	MANAGED CARE SUPPORT PRIME. MTF/PCM

EXIT.

IF NAS EXCEPTION REASON = BLANK

AND TYPE OF SERVICE (FIRST BYTE) = I. **OR** K.

AND PATIENT ZIP CODE IS IN A CATCHMENT AREA[1]

NAS NUMBER MUST BE CODED. **UNLESS**

SPONSOR BRANCH OF SERVICE = C (CHAMPVA) **OR**

	HEALTH CARE PLAN CODE	11	MCS FORT BRAGG DEMO **OR**
	ANY OCCURRENCE OF DENIAL REASON CODE	9	NON-AVAILABILITY STATEMENT NOT PROVIDED
		2	INELIGIBLE CLAIMANT
		A	DEERS
		N	MULTIPLE DENIAL REASONS
	SPECIAL PROCESSING CODE	ST	SPECIALIZED TREATMENT

OR ANY OCCURRENCE OF OVERRIDE CODE = Q (FORMER SPOUSE WITH PRE-EXISTING CONDITION). **OR**

	PROGRAM INDICATOR	H	PROGRAM FOR PERSONS WITH DISABILITIES **OR**
	SPONSOR STATUS	T	NATO

IN WHICH CASE NAS NUMBER MUST = BLANK.

2-110-06R IF SPECIAL PROCESSING FLAG

I	BERGSTROM AIR FORCE BASE	
J	LUKE/WILLIAMS AFB CATCHMENT AREA	

NAS NUMBER ≠ 46000000000

2-110-07R IF NAS EXCEPTION REASON = BLANK

AND ONE PROCEDURE CODE = (ONE OF THE APPLICABLE (I.E., CODE BASED ON DATE OF SERVICE) PROCEDURE CODES LISTED IN ADP MANUAL, CHAPTER 6, ADDENDUM A, FIGURE 6-A-2A, FIGURE 6-A-2A, FIGURE 6-A-2C, OR FIGURE 6-A-2D.

AND TYPE OF SERVICE	A	FIRST BYTE
	C	
	O	
	N	

[1] *FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.*

Element Name: NAS Exception Reason (2-180)

Validity Edits

2-180-01 VALUE MUST BE IN RANGE 1 - 9, A - Q OR BLANK

Relational Edits

	Related to Element	Edited Element Relationship	Also Relates to Element(s)
2-110-03R	NAS NUMBER		
	PATIENT ZIP CODE	SEE BELOW	SPONSOR BRANCH OF SERVICE, TYPE OF SERVICE, DENIAL REASON CODE, NAS NUMBER, BEGIN DATE OF CARE, PROGRAM INDICATOR
	SPECIAL PROCESSING CODE	SEE BELOW	PATIENT ZIP CODE, TYPE OF SERVICE, BEGIN DATE OF CARE
	PROGRAM INDICATOR	SEE BELOW	

Edited Element Relationship

NO ERROR IF SPECIAL PROCESSING CODE = MS MEDICARE SUBVENTION/TRICARE-SENIOR PRIME

BYPASS ALL NAS EXCEPTION REASON EDITING.

2-180-02R IF PATIENT ZIP CODE IS **NOT** IN A CATCHMENT AREA[1]
NAS EXCEPTION REASON MUST = BLANK
UNLESS SPECIAL PROCESSING CODE = 'ST'.

2-180-04R IF BEGINNING DATE OF CARE ≥ 9/23/96
AND

ENROLLMENT STATUS

- E MANAGED CARE SUPPORT TRICARE TIDEWATER PRIME
- O NEW ORLEANS PRIME
- H MANAGED CARE SUPPORT HOMESTEAD ENROLLED PATIENT
- K MANAGED CARE SUPPORT CALIFORNIA/ HAWAII, TRICARE PRIME ENROLLED PATIENT
- U MANAGED CARE SUPPORT PRIME, CIVILIAN PCM
- Z MANAGED CARE SUPPORT PRIME, MTF/ PCM

EXIT.

IF PATIENT ZIP CODE IS IN A CATCHMENT AREA[1] AND NAS NUMBER IS NOT CODED AND
TYPE OF SERVICE (FIRST BYTE) I INPATIENT

[1] *FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.*

Element Name: NAS Exception Reason (2-180) (Continued)

NAS EXCEPTION REASON MUST BE CODED

UNLESS

SPONSOR BRANCH OF SERVICE	C	CHAMPVA
SPECIAL PROCESSING CODE	B	EXTERNAL PARTNERSHIP PROVIDER WITH SIGNED AGREEMENT
	C	EXTERNAL PARTNERSHIP PROVIDER WITHOUT SIGNED AGREEMENT
	S	RESOURCE SHARING
	ST	SPECIALIZED TREATMENT
OR ANY OCCURRENCE OF DENIAL REASON CODE	9	NON-AVAILABILITY STATEMENT NOT PROVIDED
	2	INELIGIBLE CLAIMANT
	A	DEERS
	N	MULTIPLE DENIAL REASONS

OR ANY OCCURRENCE OF OVERRIDE CODE = 9 (FORMER SPOUSE WITH PRE-EXISTING CONDITION).

OR PROGRAM INDICATOR	H	PROGRAM FOR PERSONS WITH DISABILITIES
OR HEALTH CARE PLAN CODE	11	MCS FORT BRAGG DEMO

IN WHICH CASE NAS EXCEPTION REASON MUST BE BLANK

2-180-05R IF BEGINNING DATE OF CARE ≥ 9/23/96
AND

ENROLLMENT STATUS	E	MANAGED CARE SUPPORT TRICARE TIDEWATER PRIME
	O	NEW ORLEANS PRIME
	H	MANAGED CARE SUPPORT HOMESTEAD ENROLLED PATIENT
	K	MANAGED CARE SUPPORT CALIFORNIA/HAWAII. TRICARE PRIME ENROLLED PATIENT
	U	MANAGED CARE SUPPORT PRIME. CIVILIAN PCM
	Z	MANAGED CARE SUPPORT PRIME. MTF/PCM

EXIT.

2-180-05R

IF ANY SPECIAL PROCESSING CODE =	3	DEMONSTRATION
	4	
	6	
	9	
	E	
AND	I	
TYPE OF SERVICE	M	FIRST BYTE

AND

PATIENT ZIP CODE IS IN A CATCHMENT AREA[1].

NAS EXCEPTION REASON MUST =	9	DEMONSTRATION
UNLESS HEALTH CARE PLAN CODE	11	MCS - FORT BRAGG DEMO
IF ANY SPECIAL PROCESSING CODE =	5	LIVER/HEART TRANSPLANT
	7	
AND	I	
TYPE OF SERVICE	M	FIRST BYTE

[1] *FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.*

Element Name: NAS Exception Reason (2-180) (Continued)

AND
PATIENT ZIP CODE IS IN A CATCHMENT AREA

NAS EXCEPTION REASON MUST =	8	HEART/LIVER TRANSPLANT
UNLESS HEALTH CARE PLAN CODE	11	MCS - FORT BRAGG DEMO
IF ANY SPECIAL PROCESSING CODE	A	PARTNERSHIP PROGRAM. INTERNAL PROVIDERS WITH SIGNED AGREEMENTS
	B	PARTNERSHIP PROGRAM. EXTERNAL PROVIDERS WITH SIGNED AGREEMENTS
	C	PARTNERSHIP PROGRAM. EXTERNAL PROVIDERS WITHOUT SIGNED AGREEMENTS
	#	HOSPICE
	O	HOSPICE NON-AFFILIATED PROVIDER

AND
TYPE OF SERVICE (FIRST BYTE) = I **OR** M AND PATIENT ZIP CODE IS IN A CATCHMENT AREA[1]

NAS EXCEPTION REASON MUST	6	PARTNERSHIPS
	1	ENROLLMENT IN OHI WHICH IS PRIMARY COVERAGE
	2	EMERGENCY MEDICAL TREATMENT
	L	HOSPICE
UNLESS HEALTH CARE PLAN CODE	11	MCS - FORT BRAGG DEMO
IF ANY SPECIAL PROCESSING CODE	A	PARTNERSHIP PROGRAM. INTERNAL PROVIDERS WITH SIGNED AGREEMENTS
	B	PARTNERSHIP PROGRAM. EXTERNAL PROVIDERS WITH SIGNED AGREEMENTS
	C	PARTNERSHIP PROGRAM. EXTERNAL PROVIDERS WITHOUT SIGNED AGREEMENTS
	O	CHARLESTON NAVAL HOSPITAL CAMCHAS MTF SERVICES
	S	RESOURCE SHARING
	#	HOSPICE
	O	HOSPICE NON-AFFILIATED PROVIDER
AND	A	
TYPE OF SERVICE	C	FIRST BYTE
	O	
	N	

AND
BEGIN DATE OF CARE ≥ 11/1/91
AND
PROCEDURE CODE = (ONE OF THE APPLICABLE, i.e., CODE BASED ON DATE OF SERVICE) PROCEDURE CODES LISTED IN THE ADP MANUAL, CHAPTER 6, ADDENDUM A, FIGURE 6-A-2A, FIGURE 6-A-2A, FIGURE 6-A-2C, and FIGURE 6-A-2D.

NAS EXCEPTION REASON MUST	6	PARTNERSHIPS/RESOURCE SHARING
	1	ENROLLMENT IN OHI WHICH IS PRIMARY COVERAGE
	2	EMERGENCY MEDICAL TREATMENT
	I	TRICARE-TIDEWATER DRUG CLAIM
	J	TRICARE-TIDEWATER PREVENTATIVE CARE CLAIM

[1] *FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.*

Element Name: NAS Exception Reason (2-180) (Continued)

		L	HOSPICE
	IF ANY SPECIAL PROCESSING CODE =	AD	ACTIVE DUTY CLAIMS
	AND PATIENT ZIP CODE IS IN A CATCHMENT AREA		
	NAS EXCEPTION REASON MUST =	Q	ACTIVE DUTY CLAIMS
	UNLESS HEALTH CARE PLAN CODE	11	MCS - FORT BRAGG DEMO
2-180-06R	IF PROGRAM INDICATOR	H	PFPWD
		D	DRUGS
		T	DENTAL
	NAS EXCEPTION REASON CANNOT = 'A'.		
2-180-07R	IF PATIENT ZIP CODE IS IN A CATCHMENT AREA[1] AND NAS NUMBER IS NOT CODED		
	TYPE OF SERVICE	A	FIRST BYTE
		C	
		O	
		N	
	AND		
	BEGIN DATE OF CARE ≥ 11/1/91 AND < 9/23/966		
	AND		
	PROCEDURE CODE = (ONE OF THE APPLICABLE I.E., CODE BASED ON DATE OF SERVICE) PROCEDURE CODES LISTED IN THE ADP MANUAL, CHAPTER 6, ADDENDUM A, FIGURE 6-A-2A, FIGURE 6-A-2A, FIGURE 6-A-2C, and FIGURE 6-A-2D.		
	NAS EXCEPTION REASON MUST BE CODED, **UNLESS**.		
	SPONSOR BRANCH OF SERVICE	C	CHAMPVA **OR**
	HEALTH CARE PLAN CODE	11	MCS - FORT BRAGG DEMO
	OR		
	ANY OCCURRENCE OF DENIAL REASON CODE	9	NONAVAILABILITY STATEMENT NOT PROVIDED
		2	INELIGIBLE CLAIMANT
		A	DEERS
		N	MULTIPLE DENIAL REASONS
	OR		
	ANY OCCURRENCE OF OVERRIDE CODE	Q	FORMER SPOUSE WITH PRE-EXISTING CONDITION
	OR		
	PROGRAM INDICATOR	H	PROGRAM FOR PERSONS WITH DISABILITIES
	OR		
	SPONSOR STATUS	T	NATO
	IN WHICH CASE NAS NUMBER MUST BE = BLANK.		

[1] *FOR INTERIM BILLS CATCHMENT AREA DETERMINATION IS BASED ON EARLIEST CARE BEGIN DATE.*

Eligibility Verification

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5. *CHAMPVA claims shall be forwarded to Health Administration Center, CHAMPVA Program P.O. Box 65024, Denver CO 80206-5024.*

F. Handling Exceptions Referred by DEERS Program Office, DEERS Support Office, and Uniformed Service DEERS Project Officers

A list of key DEERS Program Office, DEERS Support Office, and Uniformed Service Project Officers is provided in Addendum D. These individuals have been designated by *TRICARE Management Activity (TMA)* and DEERS to assist DoD beneficiaries in handling cases referred by higher authorities or the Congress regarding payment of *TRICARE* claims and overriding information in the DEERS data base. When contacted by one of these individuals, either in writing or by telephone, the Contractor will provide priority handling of any claims referred by them and process the claims requested by the individual. Situations requiring such actions by the Contractor should not occur frequently and only when the DEERS data base is incomplete or incorrect. The Contractor will provide any necessary support to these individuals to assist them in the performance of their duties. When an override is performed, a written notice will be sent by DEERS to the beneficiary. The Contractor shall also use a verbal override to update their files. The override will act as a substitute for the missing documentation for processing all future claims as well as the claim(s) in question. An example would be an override for a Notice of Disallowance for a beneficiary over age 65 who is Medicare ineligible. Since the Contractor will be able to accept the overrides verbally, it is mandatory that the Contractor maintain a log of the person authorizing the override along with the date and type of override authorized. The Contractor shall only provide special support to the individuals listed in Addendum D (or his or her replacement).

G. Processing Nonavailability Statement (NAS) Data on DEERS

1. General

Inpatient Nonavailability Statement (INAS) processing is required for all programs except those specified by the Policy Manual, Chapter 11, Section 2.1. The requirements outlined in the OPM Part Two, Chapter 1, Section IV.G., (for Contractors) and in the COM-FI Part Two, Chapter 1, Section IV.G. (for FIs) apply. The automated INAS and ONAS policies apply to all 50 states, the District of Columbia, and Puerto Rico. Foreign claims requiring an INAS shall be processed with a copy of the DD Form 1251 attached to the claim form. ONAS requirements are not applicable to areas outside CONUS, Alaska, Hawaii and Puerto Rico.

NOTE:

When NAS appears in the text, it refers to both INASs and ONASs for services furnished prior to September 23, 1996.

2. Contractor Query

NOTE:

For maternity care episodes beginning on or after March 26, 1998, the hospital admission date listed on the nonavailability statement must be

within 30 days of the issue date. Nonavailability statements are no longer required for outpatient prenatal or postpartum care.

a. Whenever an INAS is required for claim payment, the query sent to DEERS shall contain a "1" in the "NAS Required Indicator" field. When an ONAS is required for claim payment, the query sent to DEERS shall contain a "2" in the "NAS Required Indicator" field. If an INAS or ONAS is not required, the query shall contain a "0" in the "NAS Required Indicator" field.

b. If an INAS is required, the Contractor shall include the date of the hospital admission or, *for maternity care episodes which began prior to March 26, 1998,* the *date of the* first prenatal maternity care visit *must be entered.* The date of admission must be coded, if the claim is from the institutional provider or the attending physician.

c. The Contractor shall attempt to retrieve the date of admission from history or previously submitted claims for all other claims associated with the inpatient admission or match the DEERS query each time a claim is submitted, depending on which method is more cost effective. The hospital admission date must be within 30 days from the issue date, EXCEPT for chronic care cases *or for maternity episodes which began prior to March 25, 1998.* In maternity cases *which began prior to March 26, 1998,* the first prenatal visit date must be the same as the issue date within the "NAS Number" field or must be the same date as the retroactive date on retroactive issuances. The NAS Number, Major Diagnostic Category, and Reason For Issuance fields must be downloaded from DEERS *unless a paper copy is attached to the claim or is on file with the provider.*

3. DEERS Reply

a. General

(1) Two types of NAS issuances, either unconditional or cancelled, can appear in the "NAS Status" field of the query response. The majority of NASs issued will appear as unconditional. A cancelled NAS is one that was issued and subsequently cancelled. A cancelled NAS shall not be used for claims processing. When the status field indicates a cancelled NAS, the Contractor shall deny any outstanding claim. The Contractor shall also check for prior claims paid on the cancelled NAS and recoup any monies paid in error.

(2) If the DEERS eligibility response code is "01" through "11", no NAS information will be included in the response.

(3) The Contractor shall process the *claim using the* NAS data on the DEERS reply in the same manner as it would process *the claim using a* hardcopy NAS forms.

b. INAS Response

(1) When DEERS has INAS data that support the INAS request in the Contractor query (or any on file when the date of admission is blank), the reply will contain the INAS number, major diagnostic category, NAS status, reason for issuance, access counter, and other insurance indicator. DEERS will return this information for any and all INASs on its file for which the claim could apply. DEERS will select the appropriate INAS for the reply by comparing the hospital admission date supplied

by the Contractor to the issue date (in Julian format) within the "NAS Number" field on the DEERS data base.

(2) When INAS data are included in the DEERS response record, DEERS will return a "1" in the "NAS Required Indicator" field on the DEERS response. The "NAS Segment Count" field will indicate the number of INASs appended to the record. A maximum of 45 INASs per dependent can be included in the record.

(3) The DEERS response will contain all INAS information for the *family member* in date-order sequence with the most recently issued INAS appearing first. If the hospital admission date, or, *for maternity episodes which began prior to March 26, 1998,* the first prenatal visit date is not included in the Contractor query, the Contractor is responsible for making date comparisons to select the proper INAS.

(4) On retroactive INASs, *including INASs for maternity care episodes beginning on or after March 26, 1996,* the "Retroactive *Date*" on the DEERS response screen shall be the hospitalization date, or, *for* maternity *care episodes which began prior to March 26, 1998,* the first prenatal visit *date.* A retroactive INAS will have an NAS number sequence between 900 and 999. (Refer to the Type 3 DEERS response of this chapter.) It will also have a retroactive effective date that is separate from the INAS issuance date located within the INAS number. The retroactive effective date will show the beginning date of the effective period of the INAS. The Contractor is not responsible for performing any consistency edits on the INAS number and the retroactive effective date.

(5) A retroactive maternity INAS will be identified by the retroactive effective date (*for maternity episodes which began prior to March 26, 1998,* the first prenatal visit *date*) and by the major diagnostic category 14. This INAS will be valid 42 days beyond the termination of the pregnancy.

(6) If the newborn remains in the hospital continuously after the mother's discharge, the mother's INAS will cover the infant in the same hospital for up to 15 days following the mother's discharge. Beyond the 15th day, the infant requires an INAS in his/her own right.

(7) When a newborn requires an INAS in his/her own right, the MTF will issue the newborn's INAS retroactive to the baby's date of birth. The Contractor will only need to query for the baby's INAS, instead of querying for both the mother and the child.

(8) For all chronic care-retroactive INAS issuances, the last three digits of the INAS number will be between 700-799.

(9) For all chronic care INAS issuances, the last three digits of the assigned INAS number will be between 800-899. (Refer to the Type 3 DEERS response of this chapter.) All chronic care INAS issuances will be valid for one year from the date of issuance.

c. ONAS Response

NOTE:

ONAS requirements apply to services provided from October 1, 1991, through September 22, 1996, only.

(1) When DEERS has ONAS data that supports the ONAS request in the Contractor query, the reply will contain the ONAS number, 2-digit code for the "Selected Outpatient Procedure Code" category, NAS status, reason for issuance, access counter, and other health insurance indicator. DEERS will return this information for any and all ONASs on its file for which the claim could apply. DEERS selects the appropriate ONASs in date order sequence by the most recently issued (in Julian format) within the "NAS Number" field. It is the Contractor's responsibility to match the closest issuance date within the "NAS Number" field to the treatment date on the claim form. All ONASs are issued for 30 days. In each instance, the treatment date on the claim form must be within the effective window period (30 days) to be matched to the ONAS.

(2) When ONAS data is included in the DEERS response record, DEERS will return a "2" in the "NAS Required Indicator" field on the DEERS response. The "NAS Segment Count" field will indicate the number of ONASs appended to the record. A maximum of 45 ONASs per dependent can be included in the record.

(3) On retroactive ONASs, the "Retroactive Date" field must be the same as the treatment date on the claim form.

4. Contractor NAS Report

Effective July 31, 1990, this report is no longer required.

5. NAS Override Authority

The persons listed in Addendum D of this chapter have NAS override authority for unusual cases.

H. Managed Care Enrollment Reporting Procedures

1. Network Primary Care Manager Selections

a. Prime enrollees selecting a network primary care manager must be updated in DEERS with the 6900 series network DMIS-ID corresponding to the enrollment region as follows:

REGION	REGION
Region 1	6901
Region 2	6902
Region 3	6903
Region 4	6904
Region 5	6905
Region 6	6906
Region 7	6907
Region 8	6908

REGION	REGION
Region 9	6909
Region 10	6910
Region 11	6911
Region 12	6912

b. The PCM Location Code will require mandatory entry of "01" for network primary care providers. There will be no default to spaces.

2. Military Treatment Facility Primary Care Manager Selections:

a. Prime enrollees selecting an MTF/Clinic primary care manager must be updated in DEERS with the specific MTF/Clinic DMIS-ID for the PCM.

b. The PCM Location Code will require mandatory entry of "00" for MTF primary care providers. There will be no default to spaces.

3. ADP Update Procedures:

a. For all PRIME enrollees including GSU enrollees resident on DEERS as of the date of this change package, the DMIS-ID and PCM Location Code will have to be researched to ensure that it complies with the instructions above. To do this the MCS contractor must first query DEERS and then their own internal history to determine how the beneficiary's DMIS-ID and PCM location fields appear now for every beneficiary in their region(s). For those records that need to be updated, the new DEERS Adjustment Transaction must be used exactly as stated in ADP Manual, Chapter 9, Addendum A. The adjustment transaction is an on-line transaction to DEERS. No cartridge/tape batch updates to DEERS will be accepted.

b. On the adjustment transaction, the existing DMIS-ID is required as well as the new DMIS-ID, for either the MTF PCM or the network PCM. DEERS will compare the old to the new as one of the cross-check measures to ensure that the correct beneficiary is being updated and that the beneficiary has not moved to a new enrolling region. If a discrepancy occurs in the new DMIS-ID, DEERS will return an error message #34 stating "Invalid Enrolling Organization DMIS-ID." If a discrepancy occurs in the existing DMIS-ID, DEERS will return an error message 36, "Incorrect Old Enrolling Organization on Adjustment Transaction."

c. As of the date of this change package, regions 9, 10, and 12, are grouped together in DEERS as DMIS-ID 6512. This 6512 DMIS-ID must be updated with 6909, 6910, and 6912, accordingly, for network providers with a PCM Location Code "01." If MTF/Clinic PCMs also currently show DMIS-ID 6512, these must also be separated into the appropriate MTF/Clinic DMIS-ID with a PCM Location Code "00." The contractor shall enter DMIS-ID 6512 for regions 9, 10, and 12 on the Adjustment Transaction in the field called "Old Enrolling Organization DMIS-ID." The contractor shall enter either the specific network PCM or MTF/Clinic PCM DMIS-ID in the field called "New Enrolling Organization DMIS-ID."

d. It is imperative that the effective date on the adjustment transaction be the same as the enrollment date already in DEERS. Do not make the effective date today's date. The effective date is NOT the effective date of the DMIS-ID update. Rather, it is the effective date of the enrollment. **The effective date must equal the enrollment date**. If these dates are not equal, DEERS will return an error code 37 "Incorrect Enrollment Date on Adjustment Transaction."

e. As stated above, the PCM Location Code requires mandatory entry. If the PCM Location Code is not "00" or "01" an error message will be returned. If "00" does not agree with an MTF/Clinic DMIS-ID, an error message will be returned as will "01" not agreeing with a network 6900 series DMIS-ID. The error message for any of these discrepant/invalid conditions is #35 "Invalid PCM Location Code."

f. Once the MCS Contractor has completed the necessary programming to correctly align the DMIS-IDs and PCM Location Codes, the contractor will be required to test for a period of 30 days prior to implementation. The MCS contractor will be required to select a variety of PRIME production records for DEERS to copy into test. The production SSNs must be reported to TSO/OCHAMPUS Information Systems for testing on DEERS. When the DEERS copy is made, the last digit of the sponsor's SSN will be converted to "7" in the test environment. The initial realignment of DMIS-IDs and PCMs will not result in a new DEERS history segment. However, any PCM changes made after the initial realignment will result in a new history segment regardless of whether the change is made during a single enrollment period. The new history segment is required to track when a beneficiary changes from a network to an MTF/Clinic PCM or vice versa.

g. For all new PRIME enrollments from the date of this change forward, the DMIS-ID will be entered on DEERS as the specific MTF/Clinic DMIS-ID for MTF/Clinic primary care manager selections or a 6900 series DMIS-ID for network primary care manager selections. The PCM Location Code will be reflected as either "00" for MTF/Clinic primary care manager selections or "01" for network primary care manager selections.

h. HCSR edits will be performed to ensure that MTF/Clinic DMIS-IDs and Enrollment Status Code "Z" agree as will HCSR edits be performed to ensure that network DMIS-IDs and Enrollment Status Code "U" agree.

i. The Enrollment Status Code "Z" shall be reported for PCM Location Code "00" whereas Enrollment Status Code "U" shall be reported for PCM Location Code "01" on HCSRs.

j. DMIS-ID reporting will be the same for the HCSR MTF Code as it is on DEERS and can be downloaded from DEERS. The HCSR MTF Code will show the specific MTF/Clinic DMIS-ID for PCM Location Code "00" or the appropriate 6900 series DMIS-ID for PCM Location Code "01".

k. MCS contractor problems and questions shall be reported to TSO/OCHAMPUS Information Systems for research by DEERS.

NOTE:

In the Tidewater area, the Tidewater contractor will still report network PCMs "01" as DMIS-ID 6501. Tidewater MTF/Clinic PCMs "00" will be reported with the specific MTF/Clinic DMIS-ID. The claims processing contractor will not be responsible for the realignment on DEERS but will be responsible for

HCSR reporting of these instructions. The HCSR reporting includes reporting Tidewater PCMs using Enrollment Status Code "U" and "Z" rather than "E".